Avera Health Plans

Member Appeal Form

Note: If you believe this case involves a medical emergency, call Avera Health Plans immediately at 605-322-4545 or toll-free at 888-322-2115

Subscriber Information

Last Name | Middle Initial | First Name | Member Plan ID Number

Street Address | City | State | ZIP

Home Phone Number | Cell Phone Number

Member Information

(If patient information is different than subscriber)

Last Name | Middle Initial | First Name | Member Plan ID Number

Street Address | City | State | ZIP

Home Phone Number | Cell Phone Number

Provider Information

(If your provider is appealing on your behalf please complete this section)

Note: Providers must have a signature from the member to authorize him or her to appeal on the member's behalf.

Provider/Medical Group Name | Phone Number

Street Address | City | State | ZIP

Is your provider authorized to appeal on your behalf? ☐ Yes ☐ No

If yes, please have the member sign below:

Member Signature

Appeal Information

Please briefly outline the specific details of your appeal and when the event(s) occurred. Include a statement regarding the outcome desired and what you believe we can do to resolve your concern. If you have copies of invoices, checks, documents or other correspondence related to the problem that may help in the investigation and resolution, please include them with this form. If you need more pages to explain the issue, please attach them to this form.

You may have the right to file an appeal on a claim decision by sending a written request and pertinent information to support your appeal within 180 days from the date of the denial or claims payment. You must submit copies of documents or other correspondence related to this appeal to help in the investigation and resolution. Refer to your current Certificate of Coverage or Summary Plan Document (SPD) for information on the appeal process. If we continue to deny payment, coverage or service requested or you do not receive a timely response to your appeal, your plan may have additional appeal options available.

You have the right, at any time throughout this process; to submit an appeal to the appropriate regulatory agency in the state the subscriber is employed. For members who work and receive their health insurance from employers located in South Dakota, call 605-773-3563; for Iowa, call 515-281-6348 and for Nebraska, call 402-471-2201.

Your plan may be governed by the Employee Retirement Income Security Act (ERISA) and you may have the right to bring a civil action under section 502(a) of ERISA after you have exhausted the mandatory appeals levels that are described in your Certificate of Coverage or Summary Plan Document.

If you have any questions regarding your coverage or appeal rights with Avera Health Plans, please call our Service Center at 605-322-4545 or toll free at 888-322-2115, 8 a.m. to 5 p.m. CT, Monday through Friday.

I certify that this information is true and correct

Member or Provider Signature

Date

Email the completed Member Appeal Form and your supporting documents to ComplaintAppeals@AveraHealthPlans.com or mail to the following address:

Attention: Complaint and Appeals Coordinator
Avera Health Plans
5300 S. Broadband Ln.
Sioux Falls, SD 57108-221